United States Department of Labor
Employees' Compensation Appeals Board

C.T., Appellant	)	
and	)	**Docket No. 06-1469**
	)	**Issued: July 25, 2007**
U.S. POSTAL SERVICE, POST OFFICE, Rivergrove, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 19, 2006 appellant filed a timely appeal of a May 8, 2006 merit decision of the Office of Workers' Compensation Programs with respect to authorization for surgery. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d)(2), the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether the Office properly denied authorization for left rotator cuff repair surgery.

FACTUAL HISTORY

The Office accepted that appellant, then a 31-year-old letter sorting machine operator, sustained several conditions as a result of an employment incident on July 6, 1979. They included a contusion of the wrist and hand on the right, tremors to the wrist, tenosynovitis of the right wrist, medial nerve neuroma of the right wrist, chronic right arm pain, ganglion cyst of synovium/tendon on the right, ganglion cyst of the synovium/tendon on the right and unspecified disorder of the bursa tendons of both shoulders; major depressive disorder single (resolved); left carpal tunnel syndrome; sprain/strain of the rotator cuff, bilateral and major depressive disorder,

recurrence, resolved. Appellant stopped work on September 14, 1981 and received appropriate compensation benefits.[1]

The record also reflects that appellant underwent numerous authorized surgeries, including a left shoulder arthroscopy, debridement of the rotator cuff, subacromial deep compression consisting of anterior acromioplasty, coracoacromial ligament resection and anterior cruciate joint resection on January 10, 2003.

On November 20, 2004 Dr. Robert Hall, a Board-certified orthopedic surgeon and treating physician, noted that appellant had pain consistent with impingement and advised that her recent magnetic resonance imaging (MRI) scan showed severe tendinopathy but no evidence of a rotator cuff tear. He noted that appellant would continue with her range of motion and strengthening exercises and return again in a month. Dr. Hall indicated that he would obtain additional views of appellant's left shoulder as she might need a second arthroscopy. On January 8, 2005 he noted that appellant had very mild crepitance with range of motion and pain at the extremes of motion. Dr. Hall noted that appellant was "considering having a redo arthroscopy on the [left] shoulder as she likely has a rotator cuff tear…." He continued to treat appellant and on July 2, 2005, advised that appellant had positive impingement signs, especially when bringing the arm down from the elevated position and noted that appellant would have a rotator cuff repair on August 16, 2005. On August 10, 2005 Dr. Hall requested authorization for a rotator cuff repair of the left shoulder.

On August 17, 2005 the Office requested an opinion from the Office medical adviser regarding whether a left shoulder rotator cuff repair was warranted and necessary to treat the accepted injury. In an August 22, 2005 report, he noted appellant's history and explained that there was no evidence that appellant's shoulder condition was accepted as work related. The medical adviser also noted that impingement syndrome was a result of excessive overhead activity, trauma, or "more frequently, as a result of the natural aging process." He noted that it did not occur as "a sequelae of carpal tunnel syndrome" and recommended denying "any shoulder condition as work related." Furthermore, the medical adviser opined that, if the left shoulder condition were accepted as work related, he would also not recommend surgery because appellant had a previous decompression of the subacromial space on the left with marginal results and a second procedure would not ensure a positive outcome. He noted that there were no imaging studies such as an MRI scan which confirmed the diagnosis provided by the treating physician of a left rotator cuff tear.

By letter dated September 9, 2005, the Office informed appellant that authorization for surgery could not be granted. Appellant was informed that an examination with a second opinion physician would be scheduled.

In a September 15, 2005 report, Dr. Hall noted that the Office medical adviser did not address the issue of tendinopathy, which was a source of pain. He explained that he intended to

[1] The record reflects that appellant received a schedule award on July 26, 1991 for a 73 percent permanent impairment of the right arm. The award ran from May 18, 1990 to September 28, 1994. Appellant appealed to the Board, which affirmed the July 26, 1991 schedule award. Docket No. 92-505 (issued October 28, 1992).

reexamine her tendinopathy arthroscopically and to complete the tear to a full thickness and repair it if it was significant. Dr. Hall requested that the Office reconsider his request for surgery.

By letter dated December 13, 2005, the Office referred appellant for a second opinion, along with a statement of accepted facts, a set of questions and the medical record to Dr. Leonard Smith, a Board-certified orthopedic surgeon.

In a December 28, 2005 report, Dr. Smith noted appellant's history of injury and treatment, which included seven surgeries on her right hand and arm. He noted that an MRI scan of the left shoulder dated January 5, 2004 revealed severe supraspinatus-infraspinatus tendinopathy with no further evidence of partial rotator cuff and postoperative changes involving the acromioclavicular joint with no evidence of impingement.[2] Dr. Smith noted that appellant stopped work on or about September 14, 1981 and has not returned. He conducted an examination of the left shoulder and noted that appellant had arthroscopic scars with tenderness over the greater tuberosity, normal stability of the glenohumeral, acromioclavicular and sternoclavicular joints. Dr. Smith advised that abduction of the shoulder was limited to 30 degrees out of an arc of 170 degrees extension is normal to 60 degrees. Furthermore, he advised that flexion is limited to 15 degrees out of an arc of 150 degrees. Dr. Smith advised that internal rotation was normal to 80 degrees and external rotation was normal to 60 degrees. He also noted that cross arm adduction was normal and backward deviation of the arm was possible to the point where the tips of the outstretched fingers came six inches beneath the scapula. Dr. Smith also noted that appellant's drop arm test was negative, and that there was some weakness in the musculature about the shoulder. He explained that appellant's prior shoulder surgery had relieved the impingement syndrome and there was nothing in the operative report to indicate any tear to the rotator cuff. Dr. Smith also advised that appellant had symptoms of tendinitis which was not amenable to operative treatment. He also indicated that appellant had seven prior surgeries to her right arm and a surgery on her left hand, as well as a "possible continuing thyroid condition" which could contribute to carpal tunnel syndrome. Dr. Smith noted that the record did not confirm of carpal tunnel syndrome. He explained that appellant's past history mitigated any further multiple surgical procedures as well as her concurrent diagnosis of depression. Dr. Smith opined that there was low probability of improvement with any further surgery and significant risks attendant to further procedures. He advised that he would not recommend any further surgical procedures on the shoulder and opined that her complaints regarding her shoulder were not related to any work-related incident and such connection would be "dubious."

In a February 4, 2006 report, Dr. Hall noted that he had reviewed Dr. Smith's report and alleged that it ignored the evolving nature of rotator cuff pathology. He explained that appellant had a rotator cuff decompression on her left shoulder on January 10, 2003 which resolved the extrinsic factors which were adversely affecting her rotator cuff. However, Dr. Hall noted that it did not eliminate her intrinsic problems, which included a poor blood supply. He indicated that, with an injury, the blood supply could be further compromised and that this is what led him to

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[2] Dr. Smith also noted that he took current x-rays of the left shoulder and that they revealed moderate degenerative changes involving the greater tuberosity and no other abnormal calcifications.

presume that appellant had a rotator cuff tear. Dr. Hall advised that at times the arthroscopy was thinned to the point where it no longer serviced appellant and caused a great deal of pain. He explained that, under these circumstances, the rotator cuff tear would be completed, freshened and repaired. Dr. Hall opined that he believed that appellant had such a problem, and thus the need for additional surgery.

By decision dated May 8, 2006, the Office denied authorization for the proposed surgery. The Office found the weight of the medical evidence did not establish that surgery was medically necessary.

LEGAL PRECEDENT

Section 8103(a) of the Federal Employees' Compensation Act provides that the United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances and supplies prescribed or recommended by a qualified physician, which the Office considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation.[3] The Office has the general objective of ensuring that an employee recovers from his injury to the fullest extent possible in the shortest amount of time. The Office therefore has broad administrative discretion in choosing means to achieve this goal.[4] The only limitation on the Office's authority is that of reasonableness.[5]

To be entitled to reimbursement for medical expenses, a claimant must establish that the expenditures were incurred for treatment of the effects of an employment-related injury.[6]

ANALYSIS

Dr. Hall, appellant's treating physician, requested authorization for arthroscopy of the left shoulder on August 10, 2005. However, an Office medical adviser questioned whether the diagnosed condition was employment related and found that, even if it were, the evidence did not support the proposed surgery as appellant had a prior surgery with marginal results, and the second procedure would not ensure a positive outcome.

The Office referred appellant for a second opinion examination with Dr. Smith, a Board-certified orthopedic surgeon to determine whether the surgery was warranted.

In a December 28, 2005 report, Dr. Smith noted appellant's history of injury and treatment. He reviewed an MRI scan of the left shoulder dated January 5, 2004 which revealed severe supraspinatus-infraspinatus tendinopathy but no further evidence of partial rotator cuff

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[3] 5 U.S.C. § 8103(a).

[4] *Dale E. Jones*, 48 ECAB 648, 649 (1997).

[5] *Daniel J. Perea*, 42 ECAB 214 (1990) (holding that abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, or actions taken which are contrary to both logic and probable deductions from established facts).

[6] *Joseph P. Hofmann*, 57 ECAB ___ (Docket No. 05-1772, issued March 9, 2006).

and no evidence of impingement. Dr. Smith also conducted an examination of the left shoulder which revealed arthroscopic scars with tenderness over the greater tuberosity, normal stability of the glenohumeral, acromioclavicular and sternoclavicular joints. He also determined her range of motion and found some weakness in the musculature about the shoulder. Dr. Smith noted that appellant's prior shoulder surgery had relieved the impingement syndrome and explained that there was nothing in the operative report to indicate that appellant had a tear to the rotator cuff. He found that appellant had symptoms of tendinitis and advised that this was not amenable to operative treatment and explained that appellant's past history mitigated any further multiple surgical procedures as well as her concurrent diagnosis of depression. Dr. Smith opined that there was low probability of improvement with any further surgery and there were significant risks with further procedures. He indicated that he would not recommend any further surgical procedures on the shoulder and opined that her complaints regarding her shoulder were not related to any work-related incident and such connection would be "dubious."

The Board finds that the weight of the medical evidence of file lies with Dr. Smith, a Board-certified orthopedic surgeon who provided a reasoned medical opinion explaining why the medical authorization in question should not be given. Dr. Smith's opinion was based on the medical evidence in file and a physical examination which was performed in his office.

Dr. Hall provided a February 4, 2006 report, in which he noted that Dr. Smith ignored the evolving nature of rotator cuff pathology and explained that appellant's rotator cuff decompression on her left shoulder on January 10, 2003 resolved the extrinsic factors which were adversely affecting her rotator cuff but did not eliminate her intrinsic problems, which included a poor blood supply. He also explained that, with an injury, the blood supply could be further compromised and that this is what led him to presume that appellant had a rotator cuff tear. However, the Board notes that there are no diagnostic studies which reveal a tear, nor was a tear accepted by the Office.

Based on the evidence of record, the Office reasonably concluded that the proposed surgery was not warranted. The Office did not abuse its discretion in denying authorization for arthroscopic surgery in this case.[7]

CONCLUSION

The Board finds that the Office properly exercised its discretion pursuant to 5 U.S.C. § 8103(a) in refusing to authorize appellant's request for arthroscopic surgery.

[7] Following the issuance of the Office's May 8, 2006 decision, appellant submitted new evidence on appeal. The Board's jurisdiction is limited to the evidence that was before the Office at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c). The Board may not consider this evidence for the first time on appeal.

ORDER

IT IS HEREBY ORDERED THAT the May 8, 2006 decision of the Office of Workers' Compensation Programs is affirmed.

Issued
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board